

SENT VIA EMAIL OR FAX ON  
Mar/09/2010

## True Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/09/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Inpatient stay for 3 day LOS for anterior cervical discectomy and interbody fusion (ACDF) at C5-6 and C6-7 levels

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 1/8/10 and 1/29/10

Radiology Reports 3/2/09, 3/27/09, 4/10/09

Test 4/22/09

Dr. 3/2/09 thru 1/27/10

3/2/09 thru 10/19/09

Dr. 4/30/09

Surgery Center 4/23/09 thru 07/08/09

OP Report 5/13/09

Dr. 12/15/09 and 1/11/10

Report Medical Eval 7/2/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a date of injury xx/xx/xx, when he was hit on the chest and fell backwards down a stairwell. He complains of neck and right upper extremity pain. He has had physical therapy, chiropractic therapy, a TENS unit, and home exercise. He underwent left shoulder surgery on 05/13/2009. His examination reveals an absent triceps jerk with hypesthesia in the C6-C7 distribution. An office visit of 12/15/2009 notes right triceps and grip weakness. The office visit of 01/11/2010 notes biceps and triceps weakness. An EMG 04/22/2009 reveals cervical radiculopathy involving the C6 nerve root bilaterally, the C7 nerve root bilaterally, and the C8 nerve root bilaterally. Also found during this same study was a demyelinating and axonal peripheral neuropathy involving the upper extremities. An MRI of the cervical spine 03/27/2009 reveals at C4-C5 a 3mm posterior and central disc herniation with impingement on the central aspect of the thecal sac. In addition, there is bilateral neuroforaminal stenosis caused by hypertrophic degenerative changes of the uncovertebral joints. At C5-C6 there is a 3mm posterior and posterolateral disc herniation with impingement on the central aspect of the thecal sac and some impingement on the right neuroforamen. In addition there is bilateral neuroforaminal stenosis caused by hypertrophic degenerative changes of the uncovertebral joints. At C6-C7 there is a 3mm posteriodisc bulge with some impingement on the thecal sac. There is bilateral neuroforaminal stenosis caused by hypertrophic uncovertebral joints. The provider is requesting an inpatient length of stay for three (3) days for anterior cervical discectomy and interbody fusion at C5-C6 and C6-C7.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The proposed surgery is medically necessary. The claimant has objective evidence of C6 and C7 radiculopathies on examination both on 12/15/2009 and 01/11/2010, as well as on EMG testing in 04/22/2009. There is neuroforaminal involvement at both C5-C6 and C6-C7. He has failed conservative measures for his symptoms. He therefore meets the ODG criteria for a cervical discectomy. A fusion is routinely performed during anterior cervical procedures, and a three-day length of stay is allowable by ODG and is standard for a two-level ACDF.

#### **References/Guidelines**

*Occupational and Disability Guidelines, "Neck and Upper Back" chapter*

#### **ODG Indications for Surgery™ -- Discectomy/laminectomy (excluding fractures):**

Washington State has published guidelines for cervical surgery for the entrapment of a single nerve root and/or multiple nerve roots. ([Washington, 2004](#)) Their recommendations require the presence of all of the following criteria prior to surgery for each nerve root that has been planned for intervention (but ODG does not agree with the EMG requirement):

- A. There must be evidence that the patient has received and failed at least a 6-8 week trial of conservative care.
- B. Etiologies of pain such as metabolic sources (diabetes/thyroid disease) non-structural radiculopathies (inflammatory, malignant or motor neuron disease), and/or peripheral sources (carpal tunnel syndrome) should be addressed prior to cervical surgical procedures.
- C. There must be evidence of sensory symptoms in a cervical distribution that correlate with the involved cervical level or presence of a positive Spurling test.
- D. There should be evidence of motor deficit or reflex changes or positive EMG findings that correlate with the cervical level. *Note:* Despite what the Washington State guidelines say, ODG recommends that EMG is optional if there is other evidence of motor deficit or reflex changes. EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms such as metabolic (diabetes/thyroid) or peripheral pathology (such as carpal tunnel). For more information, see [EMG](#).

E. An abnormal imaging (CT/myelogram and/or MRI) study must show positive findings that correlate with nerve root involvement that is found with the previous objective physical and/or diagnostic findings.

If there is no evidence of sensory, motor, reflex or EMG changes, confirmatory selective nerve root blocks may be substituted if these blocks correlate with the imaging study. The block should produce pain in the abnormal nerve root and provide at least 75% pain relief for the duration of the local anesthetic.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)